



## ***Texas Department of Insurance***

### ***Division of Workers' Compensation***

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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## **MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION**

### ***GENERAL INFORMATION***

#### **Requestor Name and Address**

MEMORIAL HOSPITAL  
PO BOX 201345  
ARLINGTON TEXAS 76006

#### **Respondent Name**

VALERO ENERGY CORP

#### **Carrier's Austin Representative Box**

Box Number 19

#### **MFDR Tracking Number**

M4-98-A659-01

### ***REQUESTOR'S POSITION SUMMARY***

**Requestor's Position Summary:** "Memorial Hospital System therefore requested your company to reprocess the claim and base the corrected payment on Fair and Reasonable Guidelines in existence immediately prior to the per diem rate structure. In our case, this was 92% of charges. This patient incurred total charges of \$1,680.85 for which we have received \$1,102.64. Therefore we request that your company issue and [sic] additional payment of \$443.74."

**Amount in Dispute:** \$578.21

### ***RESPONDENT'S POSITION SUMMARY***

**Respondent's Position Summary:** "Corporate Claims Management Inc. handles the claims for NCS/DIAMOND SHAMROCK. The carrier stands by any reductions made under the 1992 fee guideline under the theory that it based on a reasoned methodology of determining fair and reasonable charges for acute care inpatient services for the period of September 1, 1992 through July 31, 1997. We owe no additional amount."

**Response Submitted by:** Corporate Claims Management, Inc., PO Box 696080, San Antonio, Texas 78269

### ***SUMMARY OF FINDINGS***

Date(s) of Service	Disputed Services	Amount In Dispute	Amount Due
April 28, 1997 thru April 30, 1997	Inpatient Hospital Services	\$578.21	\$0.00

### ***FINDINGS AND DECISION***

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

#### **Background**

1. Former 28 Texas Administrative Code §133.305, effective June 3, 1991, 16 *Texas Register* 2830, sets out the procedures for resolving medical fee disputes.

2. Former 28 Texas Administrative Code §134.1(f) effective October 7, 1991, 16 *Texas Register* 5210, sets out the reimbursement guidelines for the services in dispute.
3. This request for medical fee dispute resolution was received by the Division on March 4, 1998.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:
  - C—Negotiated contract

## **Findings**

1. The insurance carrier did not submit documentation to support that the charges were reduced according to a negotiated contract. The insurance carriers' response indicates "The carrier stands by any reductions made under the 1992 fee guideline under the theory that it based on a reasoned methodology of determining fair and reasonable charges for acute care inpatient services." Therefore the disputed charges will be reviewed according to the guidelines in effect for this time period.
2. This dispute relates to inpatient hospital services. The former agency's *Acute Care Inpatient Hospital Fee Guideline* at 28 Texas Administrative Code §134.400, 17 *TexReg* 4949, was declared invalid in the case of *Texas Hospital Association v. Texas Workers' Compensation Commission*, 911 *South Western Reporter Second* 884 (Texas Appeals – Austin, 1995, writ of error denied January 10, 1997). As no specific fee guideline existed for acute care inpatient hospital services during the time period that the disputed services were rendered, the 1991 version of 28 Texas Administrative Code §134.1(f) applies as the proper Division rule to address fee payment issues in this dispute, as confirmed by the Court's opinion in *All Saints Health System v. Texas Workers' Compensation Commission*, 125 *South Western Reporter Third* 96 (Texas Appeals – Austin, 2003, petition for review denied). 28 Texas Administrative Code §134.1(f), effective October 7, 1991, 16 *Texas Register* 5210, requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, sec. 8.21(b), until such period that specific fee guidelines are established by the commission."
3. The former Texas Workers' Compensation Act section 8.21 was repealed, effective September 1, 1993 by Acts 1993, 73rd Legislature, chapter 269, section 5(2). Therefore, for services rendered on or after September 1, 1993, the applicable statute is the former version of Texas Labor Code section 413.011(b), Acts 1993, 73rd Legislature, chapter 269, section 1, effective September 1, 1993, which states, in pertinent part, that "Guidelines for medical services fees must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. The commission shall consider the increased security of payment afforded by this subtitle."
4. 28 Texas Administrative Code §133.305(d)(7), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "copies of all written communications and memoranda relating to the dispute." Review of the documentation submitted by the requestor finds that the request does not include a copy of medical documentation and EOBs or other written communications and memoranda pertinent to the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(7).
5. 28 Texas Administrative Code §133.305(d)(10), effective June 3, 1991, 16 *Texas Register* 2830, requires that the request shall include "a summary of the requesting party's position regarding the dispute." Review of the documentation submitted by the requestor finds that the request does not include a summary of the requesting party's position regarding the dispute. The Division concludes that the requestor has not met the requirements of §133.305(d)(10).
6. Review of the submitted documentation finds that:
  - The requestor's position statement asserts that "Memorial Hospital System therefore requested your company to reprocess the claim and base the corrected payment on Fair and Reasonable Guidelines in existence immediately prior to the per diem rate structure. In our case, this was 92% of charges. This patient incurred total charges of \$1,680.85 for which we have received \$1,102.64. Therefore we request that your company issue and [sic] additional payment of \$443.74."
  - The requestor did not submit documentation to support that "In our case, this was 92% of charges. This patient incurred total charges of \$1,680.85 for which we have received \$1,102.64. Therefore we request that your company issue and [sic] additional payment of \$443.74."
  - The Division finds that a reimbursement methodology based upon payment of a hospital's billed charges, or a percentage of billed charges, does not produce an acceptable payment amount. Such a reimbursement methodology would leave the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs. Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital's billed charges cannot be favorably considered when no other data or documentation was

submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.

- The requestor does not discuss or explain how payment of the amount sought would result in a fair and reasonable reimbursement for the services in this dispute.
- The requestor did not submit documentation to support that the payment amount being sought is a fair and reasonable rate of reimbursement for the disputed services.
- The requestor does not discuss or explain how payment of the requested amount would satisfy the requirements of 28 Texas Administrative Code §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

### **Conclusion**

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under 28 Texas Administrative Code §133.305(d). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

### ***ORDER***

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

### **Authorized Signature**

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Medical Fee Dispute Resolution Officer

\_\_\_\_\_  
October 20, 2011  
Date

### ***YOUR RIGHT TO REQUEST AN APPEAL***

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

**Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.**